Commonwealth of Massachusetts
Executive Office of Health and Human Services

September 2007 *Version 4.0*

Pharmacy Online Processing System (POPS) Billing Guide

Table of Contents

1.0 Introduction

Effective October 16, 2003, ACS State Healthcare began accepting claims for MassHealth in the NCPDP version 5.1 format.

All MassHealth pharmacy claims must be sent via the Pharmacy Online Processing System (POPS). ACS operates POPS under the general framework of standards and protocols established by the National Council for Prescription Drug Programs (NCPDP). Pharmacy Providers must work with their software and switch vendors to ensure compliance.

Switches

eRX	1-866-379-6389
NDCHealth	1-800-388-2316
WebMD\ENVOY	1-800-333-6869
QS1	1-800-231-7776

This billing guide contains pertinent information for submitting pharmacy claims to the MassHealth processing system.

Note: This document is updated regularly. The revision date above represents the most recent date that this document was updated. Please ensure that you are using the most current version of this document. For detailed information concerning updates to this document please refer to Section 13.0 – Version Table.

2.0 Claim Submission Formats – B1 and B3

BIN NUMBER:	**009555**
DESTINATION:	**ACS STATE HEALTHCARE (formerly Consultec)**
ACCEPTING:	**CLAIM ADJUDICATION (B1-BILLING AND B3-REBILL TRANSACTIONS)**
FORMAT:	**NCPDP 5.1**

2.1 Transaction Header Segment

Segment and all fields are mandatory for B1/B3 transactions.

Table Section Key

M	***Mandatory (for both NCPDP and Massachusetts)***
S	***Situational***
O	***Optional***
NS	***Not Supported***
(CC)	***Compound-Claim related***
R	***Required (for Massachusetts)***
Additional key for status column	*****R*** = repeating field**

Field	Field Name	Status	Field Size	Values
1Ø1-A1	Bin number	M	9(6)	009555
1Ø2-A2	Version/release number	M	X(2)	51
1Ø3-A3	Transaction code	M	X(2)	B1=Billing B2=Reversal B3=**Rebill**
1Ø4-A4	Processor control number	M	X(10)	MASSPROD for production transactions
1∅9-A9	Transaction count	M	X(1)	1=One occurrence 2=Two occurrences 3=Three occurrences 4=Four occurrences For B1-B3 (Billing and Rebill) transactions, transaction count must be a value of 1, 2, 3, or 4. If this transaction is for a compound claim (CC), the transaction count value must be 1.
202-B2	Service Provider ID qualifier	M	X(2)	01 – National Provider Identifier
201-B1	Service Provider ID	M	X(15)	NPI Number must be 10 characters. Contact ACS if store location is moved.
4Ø1-D1	Date of service	M	9(8)	CCYYMMDD
11∅-AK	Software vendor/certification ID	M	X(10)	This is the ID assigned by the processor to Identify the software source. This ID verifies that the software is certified.

2.2 Patient Segment Ø1

Segment is required (by Massachusetts) for B1/B3 transactions.

Field	Field Name	Status	Field Size	Values
331-CX	Patient ID qualifier	S	X(2)	Ø1=Social security number 99=Other (for IDs starting with ZZ)
332-CY	Patient ID	S	X(20)	The member's MassHealth ID
3Ø4-C4	Date of birth	R	9(8)	CCYYMMDD
3Ø5-C5	Patient gender code	R	9(1)	1=Male 2=Female
31Ø-CA	Patient first name	S	X(12)	
311-CB	Patient last name	S	X(15)	
322-CM	Patient street address	NS	X(3Ø)	
323-CN	Patient city address	NS	X(2Ø)	
324-CO	Patient state / province address	NS	X(2)	
325-CP	Patient zip/postal zone	NS	X(15)	
326-CQ	Patient phone number	NS	X(10)	
3Ø7-C7	Patient location	R	9(2)	Ø1=Home Ø2=Inter-care Ø3=Nursing facility Ø4=Long term/extended care Ø5=Rest home Ø6=Boarding home Ø7=Skilled care facility 11= Size
333-CZ	Employer ID	NS	X(15)	
334-1C	Smoker / non-smoker code	NS	X(1)	
335-2C	Pregnancy indicator	S	X(1)	Blank=Not specified 1=Not pregnant 2=Pregnant Please indicate current pregnancy status.

2.3 Insurance Segment Ø4

Segment and all fields are mandatory for B1/B3 transactions.

Field	Field Name	Status	Field Size	Values
3Ø2-C2	Cardholder ID	M	X(20)	This is the first nine digits of the member's MassHealth number.
312-CC	Cardholder first name	R	X(12)	
313-CD	Cardholder last name	R	X(20)	
314-CE	Home plan	NS		
524-FO	Plan ID	NS	X(8)	
3Ø9-C9	Eligibility clarification code	O	9(1)	Ø=Not specified 1=No override 2=Override (allowed only when activated for specific need)
336-8C	Facility ID	NS	X(10)	
3Ø1-C1	Group ID	R	X(15)	MassHealth
3Ø3-C3	Person code	O	X(3)	
3Ø6-C6	Patient relationship code	O	9(1)	Ø=Not specified 1=Cardholder 2=Spouse 3=Child 4=Other

2.4 Claim Segment Ø7

Segment and all fields are mandatory for B1/B3 transactions.

Field	Field Name	Status	Field Size	Values
455-EM	Prescription/service reference number qualifier	M	X(1)	1=Rx billing
4Ø2-D2	Prescription/service reference number	M	X(7)	
436-E1	Product/service ID qualifier	M	X(2)	Ø1=Universal product Code (UPC) Ø2=Health-related item (HRI) Ø3=National drug code (NDC)
4Ø7-D7	Product/service ID	M	X(19)	If CC, this field should be zero filled.
456-EN	Associated prescription/service reference number	S	9(7)	Used for the completion of a partial fill.
457-EP	Associated prescription/service date	S	9(8)	CCYYMMDD - Used for the completion of a partial fill. This would be the original date of fill.
458-SE	Procedure modifier code count	NS	9(1)	
459-ER	Procedure modifier code	NS	X(2)	
442-E7	Quantity dispensed	R	9(7)v99	Metric decimal quantity For CC enter the quantity of the drug in its compounded form.
4Ø3-D3	Fill number	R	9(2)	Ø=Original dispensing 1 to 99 = Refill number

Field	Field Name	Status	Field Size	Values
4Ø5-D5	Days supply	R	9(3)	On partial-fill transactions, specify only whole days dispensed.
4Ø6-D6	Compound code	R	9(1)	Ø=Not specified 1=Not a compound 2= CC
4Ø8-D8	Dispense as written (DAW)/product selection code	R	X(1)	Ø=No product selection indicated 1=Physician request 5=Brand used as generic
414-DE	Date prescription written	R	9(8)	CCYYMMDD
415-DF	Number of refills authorized	R#	9(2)	Ø through 11
419-DJ	Prescription origin code	R	9(1)	1=Written 2=Telephone 3=Electronic 4=Facsimile
42Ø-DK	Submission clarification code	R	9(2)	ØØ=Not specified Ø5=Therapy change Ø8=Process compound for approved ingredients Value of 08 allows for processing the compound claim with all (covered and noncovered) ingredients. To select submission clarification code of 08, the compound code value must be 2. If the submitter chooses not to transmit this field, the submitter is representing to MassHealth an implied “not specified” situation.
46Ø -ET	Quantity prescribed	O	9(7)V99	

Field	Field Name	Status	Field Size	Values
3Ø8-C8	Other coverage code	R	9(2)	ØØ=Not specified Ø1=No other coverage has been identified. Ø2=Other coverage exists. Payment was collected. Ø3=Other coverage exists. This claim is not covered. Ø4=Other coverage exists. Payment was not collected. Ø7=Other coverage exists and was not in effect at time of service. Ø8=Claim is a billing for a copay. If the submitter chooses not to transmit this field, they are representing to MassHealth that there is no other insurance. Therefore, a "Not Specified" situation is implied. MassHealth will reject the transaction if a COB segment is present. Values other than 00 require valid COB segment. A value of 04 should only be used in those situations where the submitter has to bill the primary payer after the fact because they don't support real time transactions (paper claim, batch, etc.) and the submitter wishes MassHealth to fully adjudicate the claim, or in those situations where the insurer will only reimburse the subscriber directly. The submitter understands that these claims must be rebilled using a B3 transaction reflecting the primary carrier payment within 90 days from the date of service or the claim is automatically reversed. A value of 08 must be used only when the other insurer has applied 100% of the billed amount to the patient responsibility.
429-DT	Unit dose indicator	O	9(1)	Ø=Not specified 1=Not unit dose 2=Manufacturer unit dose 3=Pharmacy unit dose 4=Custom packaging
453-EJ	Originally prescribed product/service ID qualifier	O	X(2)	Ø1=Universal product code (UPC) Ø2=Health-related item (HRI) Ø3=National drug code (NDC) This is used for a completion of a partial fill.
445-EA	Originally prescribed product/service code	O	X(19)	This can be a different NDC from the original fill, but must be the same GSN.
446-EB	Originally prescribed quantity	O	9(7)v99	
33∅-CW	Alternate ID	NS	X(20)	
454-EK	Scheduled prescription ID number	NS	X(12)	
6ØØ-28	Unit of measure	S	X(2)	EA=Each GM=Grams ML=Milliliters Not required for CC. Will use field 451-EG instead.

Field	Field Name	Status	Field Size	Values
418-DI	Level of service	S	9(2)	ØØ=Not specified Ø1=Patient consultation Ø2=Home delivery Ø3=Emergency Ø4=24-hour service Ø5=Patient consultation about generic product selection Ø6=In-home service
461-EU	Prior authorization type code	S	9(1)	Ø=Not specified 1=Prior authorization 2=Medical certification
462-EV	Prior authorization number submitted	S	9(11)	Required entry for claims submitted on behalf of 340B clinics for indirect billing. Authorization number is provided during registration.
463-EW	Intermediary authorization type ID	NS	9(2)	
464-EX	Intermediary authorization ID	NS	X(11)	
343-HD	Dispensing status	S	X(1)	This field is used and required only for partial-fill/complete actions. A value of 'P' is required along with the quantity and days supply intended to be dispensed on the initial fill. A value of 'C' will be required on the completion fill along with the associate pharmacy/service reference number and associate pharmacy/service date. If transaction is a B3-Rebill, you cannot submit a dispensing status of 'P' (partial) or 'C' (completion). Values of 'P' and 'C' are valid only for B1.
344-HF	Quantity intended to be dispensed	S	9(7)V99	Required for partials and completions
345-HG	Days supply intended to be dispensed	S	9(3)	Required for partials and completions

2.5 Pharmacy Provider Segment Ø2

Segment is optional for B1/B3 transactions.

Field	Field Name	Status	Field Size	Values
465-EY	Provider ID qualifier	O	X(2)	Blank=Not specified Ø1=Drug Enforcement Administration (DEA) Ø2=State license Ø3=Social security number (SSN) Ø4=Name Ø5=National Provider Identifier (NPI) Ø6=Health industry number (HIN) Ø7=State issued 99=Other
444-E9	Provider ID	O	X(15)	

2.6 Prescriber Segment Ø3

Segment is required (by MA) for B1/B3 transactions.

Field	Field Name	Status	Field Size	Values
466-EZ	Prescriber ID qualifier	R	X(2)	Ø5=Medicaid Ø8=State license 12=Drug Enforcement Administration (DEA)
411-DB	Prescriber ID	R	X(15)	A nine-character DEA number must be used if the drug schedule for the drug dispensed is 2-5. For schedule 0 or 6 drugs, a DEA number with a qualifier of 12 is preferred. If the prescriber does not hold a DEA number and the prescriber is enrolled in MassHealth, the seven-digit MassHealth number with a qualifier of 05 should be used. For prescribers not enrolled in MassHealth, a MA state license number with a qualifier of 08 can be used.
467-1E	Prescriber location code	NS	X(3)	
427-DR	Prescriber last name	NS	X(15)	
498-PM	Prescriber phone number	NS	9(10)	
468-2E	Primary care Provider ID qualifier	O	X(2)	Blank=Not specified Ø1=National Provider Identifier (NPI) Ø2=Blue Cross Ø3=Blue Shield Ø4=Medicare Ø5=Medicaid Ø6=UPIN Ø7=NCPDP provider ID Ø8=State license Ø9=TriCare 1Ø=Health industry number (HIN) 11=Federal tax ID 12=Drug Enforcement Administration (DEA) 13=State issued 14=Plan specific 99=Other
421-DL	Primary care provider ID	O	X(15)	
469-H5	Primary care provider location code	NS	X(3)	
47∅-4E	Primary care provider last name	NS	X(15)	

2.7 COB/Other Payments Segment Ø5

Segment is situational for B1/B3 transactions. It is processed where MassHealth is not the primary payer.

Field	Field Name	Status	Field Size	Values
337-4C	Coordination of benefits/other payments count	M	9(1)	
338-5C	Other payer coverage type	M***R***	X(2)	Blank=Not specified Ø1=Primary Ø2=Secondary Ø3=Tertiary 98=Coupon 99=Composite
339-6C	Other payer ID qualifier	S***R***	X(2)	Blank=Not specified 99=Other
34∅-7C	Other payer ID	S***R***	X(10)	Enter the five-digit MassHealth carrier ID where member has primary commercial or Medicare-C coverage. For Medicare-D, enter the six-digit MassHealth PDP carrier code or BIN-PCN of the PDP.
443-E8	Other payer date	S***R***	9(8)	CCYYMMDD
341-HB	Other payer amount paid count	S	9(1)	
342-HC	Other payer amount paid qualifier	S***R***	X(2)	Ø7=Drug benefit 99=Other A value of 99 will communicate MassHealth member liability from the other insurer.
431-DV	Other payer amount paid	S***R***	s9(6)v99	s$$$$$$cc 1. When you have received money from private insurance as well as the patient, use value of 07-drug benefit in Field 342 and put the amount in Field 509 into this field (431). 2. Create a second instance, using a qualifier of 99 in Field 342, and indicate the patient-paid amount regarding private insurance from Field 505 in the second instance of this field.
471-5E	Other payer reject count	S	9(2)	Only populated when claim denies from other insurance (Medicare or private).

Field	Field Name	Status	Field Size	Values
472-6E	Other Payer Reject Codes	S***R***	X(3)	With Other Coverage Code 03: • 6Ø - Product/service is not covered for patient age. • 61 - Product/service is not covered for patient gender. • 63 - Institutionalized patient product/service ID is not covered. • 65 - Patient is not covered. • 66 - Patient age exceeds the maximum age. • 67 - Filled before coverage is effective. • 68 - Filled after coverage expired. • 69 - Filled after coverage was terminated. • 7Ø - Product/service is not covered. • 71 - Prescriber is not covered. • 76 - Plan limitations were exceeded. • AA - Patient spend-down was not met. • M1 - Patient is not covered in this aid category. • RN - Plan limits were exceeded on intended partial fill values. MassHealth will pay only as the primary payer when one of the other payer reject codes listed above is received. Other Coverage Code 03 for dually eligible members (Medicare Part D) for Part D excluded products: • AC - Product is not covered , non-participating manufacturer • AF - Patients are enrolled under managed care. • MI - Patient is not covered in this aid category. • 07 - M/I cardholder ID Number • 52 - Non-matched cardholder ID • 6Ø - Product/service is not covered for patient age. • 61 - Product/service is not covered for patient gender. • 63 - Institutionalized patient product/service ID is not covered. • 65 - Patient is not covered. • 7Ø - Product/service is not covered. • 75 - Prior authorization is required. Other Coverage Code 07: • 67 - Filled before coverage was effective. • 68 - Filled after coverage expired. • 69 - Filled after coverage was terminated. • 76 - Plan limitations were exceeded.

2.8 Workers' Compensation Segment Ø6

Segment is optional for B1/B3 transactions.

Field	Field Name	Status	Field Size	Values
434-DY	Date of injury	M	9(8)	CCYYMMDD
315-CF	Employer name	NS		
316-CG	Employer street address	NS		
317-CH	Employer city address	NS		
318-CI	Employer state/province address	NS		
319-CJ	Employer zip/postal zone	NS		
32Ø-CK	Employer phone number	NS		
321-CL	Employer contact name	NS		
327-CR	Carrier ID	NS		
435-DZ	Claim/reference ID	O	X(30)	

2.9 DUR/PPS Segment Ø8

Segment is situational for B1/B3 transactions.

Field	Field Name	Status	Field Size	Values
473-7E	DUR/PPS code counter	S***R***	9(1)	
439-E4	Reason for service code (also known as the DUR conflict code)	S***R***	X(2)	DD=Drug-drug interaction HD=High dose ID=Ingredient duplication TD=Therapeutic These values will permit override consideration. You will also have to give corresponding entries for Fields 440 and 441 (DUR disc.).
44Ø-E5	Professional service code (also known as the DUR intervention code)	S***R***	X(2)	MØ=Prescriber consulted RØ=Pharmacist consulted other source These values will permit override consideration.
441-E6	Result of service code (also known as the DUR outcome code)	S***R***	X(2)	1A=Filled as is, false positive 1B=Filled prescription as is 1C=Filled, with different dose 1D=Filled, with different directions 1E=Filled, with different drug 1F=Filled, with different quantity 1G=Filled, with prescriber approval These values will permit override consideration.
474-8E	DUR/PPS level of effort	O	9(2)	ØØ =Not specified 11=Level 1 – Less than 5 min. 12=Level 2 – Less than 15 min. 13=Level 3 – Less than 30 min. 14=Level 4 – Less than 1 hour 15=Level 5 – Greater than 1 hour

Field	Field Name	Status	Field Size	Values
475-J9	DUR co-agent ID qualifier	O	X(2)	Ø1= Universal product code (UPC) Ø2= Health-related item (HRI) Ø3= National drug code (NDC) Ø4= Universal product number (UPN) Ø5= Department of Defense (DOD) Ø7= Common procedure terminology CPT4) Ø8= Common procedure terminology (CPT5) Ø9= Health Care Financing Administration Common Procedural Coding System (HCPCS) 11= National Pharmaceutical Product Interface code (NAPPI) 12= International article numbering system (EAN) 13= Drug Identification number (DIN) 14= Medi-Span GPI 15= First DataBank GCN 16= Medical Economics GPO 17= Medi-Span DDID 18= First DataBank SmartKey 19= Medical Economics GM 20= International classification of diseases (ICD9) 21= International classification of diseases (ICD1Ø) 22= Medi-span diagnosis code 23= National Criteria Care Institute (NCCI) 24= The Systematized Nomenclature of Human and Veterinary Medicine (SNOMED) 25= Common dental terminology (CDT) 26= American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV) 99= Other
476-H6	DUR co-agent DI	O	X(19)	

2.10 Pricing Segment 11

Segment is mandatory for B1/B3 transactions.

Field	Field Name	Status	Field Size	Values
4Ø9-D9	Ingredient cost submitted	R	s9(6)v99	
412-DC	Dispensing fee submitted	R	s9(6)v99	
477-BE	Professional service fee submitted	S	s9(6)v99	
433-DX	Patient paid amount submitted	R	s9(6)v99	This is the amount of the patient's responsibility as stated by the primary payer.
438-E3	Incentive amount submitted	NS	s9(6)v99	
478-H7	Other amount claimed submitted count	S	9(1)	Used for return to stock and 340B programs.
479-H8	Other amount claimed submitted qualifier	S	X(2)	Blank=Not specified Ø4=Administrative cost A value of 04 should be used if you are participating in MassHealth return to stock or MassHealth 340B program.
48∅-H9	Other amount claimed submitted	S	s9(6)v99	If you are participating in MassHealth return to stock or MassHealth 340B program, enter the administrative fee in this field.
481-HA	Flat sales tax amount submitted	NS	s9(6)v99	
482-GE	Percentage sales tax amount submitted	NS	s9(6)v99	
483-HE	Percentage sales tax rate submitted	NS	s9(3)v4	
484-JE	Percentage sales tax basis submitted	NS	X(2)	
426-DQ	Usual and customary charge	R	s9(6)v99	
43Ø-DU	Gross amount due	R	s9(6)v99	
423-DN	Basis of cost determination	O	X(2)	Blank=Not specified ØØ=Not specified Ø1=Average wholesale price (AWP) Ø2=Local wholesaler Ø3=Direct Ø4=Estimated acquisition cost (EAC) Ø5=Acquisition Ø6=Maximum allowable cost (MAC) Ø7=Usual and customary (default) Ø9=Other

2.11 Coupon Segment Ø9 (Segment not supported by MassHealth.)

2.12 Compound Segment 1Ø

If compound code = 2-compound, all fields in this segment (except for Compound Ingredient Basis of Cost Determination) are mandatory.

Field	Field Name	Status	Field Size	Values
45Ø-EF	Compound dosage form description code	M	X(2)	Blank=Not specified Ø1=Capsule Ø2=Ointment Ø3=Cream Ø4=Suppository Ø5=Powder Ø6=Emulsion Ø7=Liquid 1Ø=Tablet 11=Solution 12=Suspension 13=Lotion 14=Shampoo 15=Elixir 16=Syrup 17=Lozenge 18=Enema
451-EG	Compound dispensing unit form indicator	M	9(1)	1=Each 2=Grams 3=Milliliters
452-EH	Compound route of administration	M	9(2)	ØØ=Not specified Ø1=Buccal Ø2=Dental Ø3=Inhalation Ø4=Injection Ø5=Intraperitoneal Ø6=Irrigation Ø7=Mouth/throat Ø8=Mucous membrane Ø9=Nasal 1Ø=Ophthalmic 11=Oral 12=Other/miscellaneous 13=Otic 14=Perfusion 15=Rectal 16=Sublingual 17=Topical Size 18=Transdermal 19=Translingual 2Ø=Urethral 21=Vaginal 22=Enteral
447-EC	Compound ingredient component count	M	9(2)	

Field	Field Name	Status	Field Size	Values
488-RE	Compound product ID qualifier	M***R***	X(2)	Ø1=Universal product code (UPC) Ø2=Health-related item (HRI) Ø3=National drug code (NDC) (default)
489-TE	Compound product ID	M***R***	X(19)	
448-ED	Compound ingredient quantity	M***R***	9(7)v999	Metric decimal equivalent
449-EE	Compound ingredient drug cost	R***R***	s9(6)v99	
49∅-UE	Compound ingredient basis of cost determination	O***R***	X(2)	Blank=Not specified Ø1=Average wholesale price (AWP) Ø2=Local wholesaler Ø3=Direct Ø4=Estimated acquisition cost (EAC) Ø5=Acquisition Ø6=Maximum allowable cost (MAC) Ø7=Usual and customary (default) Ø9=Other

2.13 Prior Authorization Segment 12 (Segment not supported by MassHealth.)

2.14 Clinical Segment 13

Segment not supported for B1/B3 transactions.

Field	Field Name	Status	Field Size	Values
491-VE	Diagnosis code count	O	9(1)	
492-WE	Diagnosis code qualifier	O***R***	X(2)	Blank=Not specified ØØ=Not specified Ø1=International classification of diseases (ICD9) Ø2=International classification of diseases (ICD1Ø) Ø3=National Criteria Care Institute (NCCI) Ø4=The Systematized Nomenclature of Human and Veterinary Medicine (SNOMED) Ø5=Common dental terminology (CDT) Ø6=Medi-Span diagnosis code Ø7=American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV) 99=Other
424-DO	Diagnosis code	O***R***	X(15)	
493-XE	Clinical information counter	O***R***	9(1)	
494-ZE	Measurement date	O***R***	9(8)	CCYYMMDD
495-H1	Measurement time	O***R***	9(4)	HHMM

Field	Field Name	Status	Field Size	Values
496-H2	Measurement dimension	O***R***	X(2)	Blank=Not specified Ø1=Blood pressure (BP) Ø2=Blood glucose level Ø3=Temperature Ø4=Serum creatinine (SCr) Ø5=HbA1c Ø6=Sodium (Na+) Ø7=Potassium (K+) Ø8=Calcium (Ca++) Ø9=Serum glutamic-oxaloacetic transaminase (SGOT) 1Ø=Serum glutamic-pyruvic transaminase (SGPT) 11=Alkaline phosphatase 12=Serum theophylline level 13=Serum digoxin level 14=Weight 15=Body surface area (BSA) 16=Height 17=Creatinine clearance (CrCl) 18=Cholesterol 19=Low-density lipoprotein (LDL) 2Ø=High-density lipoprotein (HDL) 21=Triglycerides (TG) 22=Bone mineral density (BMD T-Score) 23=Prothrombin time (PT) 24=Hemoglobin (Hb; Hgb) 25=Hematocrit (Hct) 26=White blood cell count (WBC) 27=Red blood cell count (RBC) 28=Heart rate 29=Absolute neutrophil count (ANC) 3Ø=Activated Partial thromboplastin time (APTT) 31=CD4 count 32=Partial thromboplastin time (PTT) 33=T-cell count 34=International Normalized Ratio (INR) 99=Other

Field	Field Name	Status	Field Size	Values
497-H3	Measurement unit	O***R***	X(2)	Blank=Not specified Ø1=Inches (in) Ø2=Centimeters (cm) Ø3=Pounds (lb) Ø4=Kilograms (kg) Ø5=Celsius (C) Ø6=Fahrenheit (F) Ø7=Meters squared (m2) Ø8=Milligrams per deciliter (mg/dl) Ø9=Units per milliliter (U/ml) 1Ø=Millimeters of mercury (mmHg) 11=Centimeters squared (cm2) 12=Millimeters per minute (ml/min) 13=Percentage (%) 14=Milliequivalent (mEq/ml) 15=International units per liter (IU/L) 16=Micrograms per milliliter (mcg/ml) 17=Nanograms per milliliter (ng/ml) 18=Milligrams per milliliter (mg/ml) 19=Ratio 2Ø=SI units 21=Millimoles (mmol/l) 22=Seconds 23=Grams per deciliter (g/dl) 24=Cells per cubic millimeter (cells/cu mm) 25=1,ØØØ,ØØØ cells per cubic millimeter (million cells/cu mm) 26=Standard deviation 27=Beats per minute
499-H4	Measurement value	O***R***	X(15)	Blood pressure entered in XXX/YYY format in which XXX=systolic, /=divider, and YYY is diastolic Temperature entered in XXX.X format always including decimal point Request clinical segment

3.0 Claim Response Formats - B1 and B3

3.1 Billing Response (B1) Transmission Level

Segment and all fields are mandatory for all transmissions/transactions. The response header segment is used when a response is sent back to the Provider.

Table Section Key

M	***Mandatory (for both NCPDP and MA)***
S	***Situational***
O	***Optional***
NS	***Not Supported***
(CC)	***Compound-Code related***
R	***Required (for Massachusetts)***
Additional key for status column	*****R*** = repeating field**

Response Header Segment

Field	Field Name	Status	Field Size	Values
1Ø2-A2	Version/release number	M	X(2)	51
1Ø3-A3	Transaction code	M	X(2)	B1=Billing B2=Reversal B3=**Rebill**
1∅9-A9	Transaction count	M	X(1)	1=One occurrence 2=Two occurrences 3=Three occurrences 4=Four occurrences For B1-B3 (billing, reversal, and rebill) transactions, transaction count will be a value of 1, 2, 3, or 4. If this transaction is for a compound claim, the transaction count value must be 1.
5Ø1-F1	Header response status	M	X(1)	A=Accepted R=Rejected This is the status of the entire transmission and does not relate to a specific transaction.
202-B2	Service Provider ID qualifier	M	X(2)	01 – National Provider Identifier
201-B1	Service Provider ID	M	X(15)	NPI Number must be 10 characters. Contact ACS if store location has moved.
4Ø1-D1	Date of service	M	9(8)	CCYYMMDD

3.1.1 Response Message Segment 2Ø

Segment is optional for all transmissions/transactions.

Field	Field Name	Status	Field Size	Values
5Ø4-F4	Message	O	X(200)	This field is populated with a hyphenated transaction control number (TCN) followed by a variable message (concatenated).

3.1.2 Transaction Level Response Status Segment 21

Segment is mandatory for all transactions.

Field	Field Name	Status	Field Size	Values
112-AN	Transaction response status	M	X(1)	P=Paid D=Duplicate R=Rejected
5Ø3-F3	Authorization number	S	X(20)	This field is mandatory when a reject response is returned.
51Ø-FA	Reject count	S	9(2)	This field is mandatory when a reject response is returned. This is the count of denied exception codes only.
511-FB	Reject code	S***R***	X(3)	This field is mandatory when a reject response is returned.
546-4F	Reject field occurrence indicator	O	9(2)	This is the number of rejected fields.
526-FQ	Additional message information	O	X(200)	
547-5F	Approved message code count	O	9(1)	Not populated.
548-6F	Approved message code	O***R***	X(3)	Not populated.
549-7F	Help desk phone number qualifier	O	X(2)	Not populated.
55∅-8F	Help desk phone number	O	X(18)	Not populated.

3.1.3 Response Claim Segment 22

Segment is mandatory for all transactions.

Field	Field Name	Status	Field Size	Values
455-EM	Prescription/service reference number qualifier	M	X(1)	1=Rx billing
4Ø2-D2	Prescription/service reference number	M	X(7)	
551-9F	Preferred product count	O	9(1)	Not populated.
552-AP	Preferred product ID qualifier	O***R***	X(2)	Not populated.
553-AR	Preferred product ID	O***R***	X(19)	Not populated.
554-AS	Preferred product incentive	O***R***	9(6)V99	Not populated.
555-AT	Preferred product copay incentive	O***R***	9(6)V99	Not populated.
556-AU	Preferred product description	O***R***	X(40)	Not populated.

3.1.4 Response Pricing Segment 23

Segment is mandatory for paid response and optional for captured response.

Field	Field Name	Status	Field Size	Values
5Ø5-F5	Patient pay amount	S	9(6)V99	Sent for paid claims (where field 112-AN = P)
5Ø6-F6	Ingredient cost paid	O	9(6)V99	Sent for paid claims (where field 112-AN = P)
5Ø7-F7	Dispensing fee paid	O	9(6)V99	Sent for paid claims (where field 112-AN = P) Populated with the lesser of the submitted dispensing fee or calculated dispensing fee.
557-AV	Tax exempt indicator	O	X(1)	Not populated.
558-AW	Flat sales tax amount paid	O	9(6)V99	Not populated.
559-AX	Percentage sales tax amount paid	O	9(6)V99	N/A to MA.
56∅-AY	Percentage sales tax rate paid	O	9(3)V9999	Not populated.
561-AZ	Percentage sales tax basis paid	O	X(2)	Not populated.
521-FL	Incentive amount paid	O	9(6)V99	Not populated.
562-J1	Professional service fee paid	O	9(6)V99	Not populated.
563-J2	Other amount paid count	O	9(1)	Not populated.
564-J3	Other amount paid qualifier	O***R***	X(2)	Not populated.
565-J4	Other amount paid	O***R***	9(6)V99	Not populated.
5Ø9-F9	Total amount paid	S	9(6)V99	Sent for paid claims (where field 112-AN = P)
522-FM	Basis of reimbursement determination	O	9(2)	
523-FN	Amount attributed to sales tax	O	9(6)V99	Not populated.
512-FC	Accumulated deductible amount	O	9(6)V99	Not populated.
513-FD	Remaining deductible amount	O	9(6)V99	Not populated.
514-FE	Remaining benefit amount	O	9(6)V99	999999.00
517-FH	Amount applied to periodic deductible	O	9(6)V99	ACS sends back
518-FI	Amount of copay/co-insurance	O	9(6)V99	Copayment amount - ACS sends back
519-FJ	Amount attributed to product selection	O	9(6)V99	DAW difference – ACS sends back
52Ø-FK	Amount exceeding periodic benefit maximum	O	9(6)V99	ACS sends back, but may not apply to MA
346-HH	Basis of calculation.-.dispensing fee	O	X(2)	Not populated.
347-HJ	Basis of calculation.-.copay	O	X(2)	Not populated.
348-HK	Basis of calculation.-.flat sales tax	O	X(2)	Not populated.
349-HM	Basis of calculation.-.percentage sales tax	O	X(2)	Not populated.

3.1.5 Response DUR/PPS Segment 24

Segment is situational for all transactions. Maximum of up to nine occurrences allowed.

Field	Field Name	Status	Field Size	Values
567-J6	DUR/PPS response code counter	O***R***	9(1)	There is a maximum of up to nine occurrences.
439-E4	Reason for service code (formerly, the DUR conflict code)	O***R***	X(2)	DD=Drug-drug interaction HD=High dose ID=Ingredient duplication TD=Therapeutic **These values will permit override consideration.**
528-FS	Clinical significance code	O***R***	X(1)	
529-FT	Other pharmacy indicator	O***R***	9(1)	
53Ø-FU	Previous date of fill	O***R***	9(8)	
531-FV	Quantity of previous fill	O***R***	9(7)V999	
532-FW	Database indicator	O***R***	X(1)	
533-FX	Other prescriber indicator	O***R***	9(1)	
544-FY	DUR free text message	O***R***	X(30)	

3.1.6 Response Insurance Segment 25

Segment is optional for all transmissions/transactions.

Field	Field Name	Status	Field	Values
3Ø1-C1	Group ID	O	X(15)	ALTH
524-FO	Plan ID	O	X(8)	ACS sends back
545-2F	Network reimbursement ID	O	X(10)	Not populated.
568-J7	Payer ID qualifier	O	X(2)	Not populated.
569-J8	Payer ID	O	X(10)	Not populated.

3.2 Rebill Response (B3) Transmission Level

Segment and all fields are mandatory for all transmissions/transactions.

Response Header Segment				
Field	**Field Name**	**Status**	**Field Size**	**Values**
1Ø2-A2	Version/release number	M	X(2)	51
1Ø3-A3	Transaction code	M	X(2)	B1=Billing B2=Reversal B3=**Rebill**
1Ø9-A9	Transaction count	M	X(1)	1=One occurrence 2=Two occurrences 3=Three occurrences 4=Four occurrences For B1-B3 (billing, reversal, and rebill) transactions, transaction count will be a value of 1, 2, 3, or 4. If this transaction is for a CC, the transaction count value must be 1.
5Ø1-F1	Header response status	M	X(1)	A=Accepted R=Rejected This is the status of the entire transmission and does not relate to a specific transaction.
202-B2	Service Provider ID qualifier	M	X(2)	01=National provider identifier
201-B1	Service Provider ID	M	X(15)	NPI number must be 10 characters. Contact ACS if store location has moved.
4Ø1-D1	Date of service	M	9(8)	CCYYMMDD

3.2.1 Transaction Level Response Status Segment 21

Segment is mandatory for all transactions.

Field	Field Name	Status	Field Size	Values
112-AN	Transaction response status	M	X(1)	P=Paid R=Rejected
503-F3	Authorization number	S	X(20)	Sent for paid claims (where field 112-AN = P).
510-FA	Reject count	S	9(2)	This field is mandatory when a reject response is returned. This is the count of denied exception codes only.
511-FB	Reject code	S***R***	X(3)	This field is mandatory when a reject response is returned.
546-4F	Reject field occurrence indicator	S	9(2)	This is the number of rejected fields. This is only sent when the claim is rejected (where field 112-AN = R).
526-FQ	Additional message information	O	X(200)	This field is populated with a hyphenated transaction control number (TCN) followed by a variable message (concatenated).
547-5F	Approved message code count	O	9(1)	Not populated. (Not used)
548-6F	Approved message code	O***R***	X(3)	Not populated. (Not used)
549-7F	Help desk phone number qualifier	O	X(2)	Not populated.
550-8F	Help desk phone number	O	X(18)	Not populated.

3.2.2 Response Claim Segment 22

Segment is mandatory for all paid transactions.

Field	Field Name	Status	Field Size	Values
455-EM	Prescription/service reference number qualifier	M	X(1)	1=Rx billing
4Ø2-D2	Prescription/service reference number	M	X(7)	
551-9F	Preferred product count	O	9(1)	Not populated. ACS will not send.
552-AP	Preferred product ID qualifier	O***R***	X(2)	Not populated.
553-AR	Preferred product ID	O***R***	X(19)	Not populated.
554-AS	Preferred product incentive	O***R***	9(6)V99	Not populated.
555-AT	Preferred product copay incentive	O***R***	9(6)V99	Not populated.
557-AU	Preferred product description	O***R***	X(40)	Not populated.

3.2.3 Response Pricing Segment 23

Segment is mandatory for paid response and optional for captured response.

Field	Field Name	Status	Field Size	Values
5Ø5-F5	Patient pay amount	S	9(6)V99	Sent for paid claims (where field 112-AN = P).
5Ø6-F6	Ingredient cost paid	S	9(6)V99	Sent for paid claims (where field 112-AN = P).
5Ø7-F7	Dispensing fee paid	S	9(6)V99	Sent for paid claims (where field 112-AN = P). Populated with the lesser of the submitted dispensing fee or calculated dispensing fee.
557-AV	Tax exempt indicator	O	X(1)	Not populated.
5Ø9-F9	Total amount paid	O	9(6)V99	ACS sends back.
522-FM	Basis of reimbursement determination	O	9(2)	ACS sends back.

4.0 Claim Reversal Format - B2

Massachusetts	
BIN NUMBER:	**009555**
DESTINATION:	**ACS STATE HEALTHCARE**
ACCEPTING:	**CLAIM ADJUDICATION (B2-REVERSAL TRANSACTIONS)**
FORMAT:	**NCPDP 5.1**

4.1 Transaction Header Segment

Table Section Key

M	***Mandatory (for both NCPDP and MA)***
S	***Situational***
O	***Optional***
NS	***Not Supported***
(CC)	***Compound-Code related***
R	***Required (for MA)***
Additional key for status column	*****R*** = repeating field**

Field	Field Name	Status	Field Size	Values
1Ø1-A1	Bin number	M	9(6)	009555
1Ø2-A2	Version/release number	M	X(2)	51
1Ø3-A3	Transaction code	M	X(2)	B1=Billing B2=Reversal B3=**Rebill**
1Ø4-A4	Processor control number	M	X(10)	MASSPROD for production transactions

Field	Field Name	Status	Field Size	Values
1∅9-A9	Transaction count	M	X(1)	1=One occurrence 2=Two occurrences 3=Three occurrences 4=Four occurrences For B1-B3 (billing, reversal, and rebill) transactions, transaction count must be a value of 1, 2, 3, or 4.
202-B2	Service Provider ID qualifier	M	X(2)	01=National provider identifier
201-B1	Service Provider ID	M	X(15)	NPI Number must be 10 characters. Contact ACS if store location has moved.
4Ø1-D1	Date of service	M	9(8)	CCYYMMDD
11∅-AK	Software vendor/certification ID	M	X(10)	This is the ID assigned by the processor to Identify the software source. This ID verifies that the software is certified.

4.2 Patient Segment Ø1 (Segment not supported by MassHealth.)

4.3 Insurance Segment Ø4

Field	Field Name	Status	Field Size	Values
3Ø2-C2	Cardholder ID	O	X(20)	**Optional field for reversals** This is the first nine digits of the member's MassHealth ID number.
312-CC	Cardholder first name	NS	X(12)	
313-CD	Cardholder last name	NS	X(20)	
314-CE	Home plan	NS		
524-FO	Plan ID	NS	X(8)	
3Ø9-C9	Eligibility clarification code	O	9(1)	Ø=Not specified 1=No override 2=Override (allowed only when activated for specific need)
336-8C	Facility ID	NS	X(10)	
3Ø1-C1	Group ID	R	X(15)	MassHealth
3Ø3-C3	Person code	O	X(3)	
3Ø6-C6	Patient relationship code	O	9(1)	Ø=Not specified 1=Cardholder 2=Spouse 3=Child 4=Other

4.4 Claim Segment Ø7

Field	Field Name	Status	Field Size	Values
455-EM	Prescription/service reference number qualifier	M	X(1)	1=Rx billing
4Ø2-D2	Prescription/service reference number	M	X(7)	
436-E1	Product/service ID qualifier	M	X(2)	Ø1=Universal product code (UPC) Ø2=Health-related item (HRI) Ø3=National drug code (NDC) Space fill
4Ø7-D7	Product/service ID	M	X(19)	Space fill
456-EN	Associated prescription/service reference number	NS	9(7)	
457-EP	Associated prescription/service date	NS	9(8)	
458-SE	Procedure modifier code count	NS	9(1)	
459-ER	Procedure modifier code	NS	X(2)	
442-E7	Quantity dispensed	NS	9(7)v99	
4Ø3-D3	Fill number	NS	9(2)	
4Ø5-D5	Days supply	NS	9(3)	
4Ø6-D6	Compound code	NS	9(1)	
4Ø8-D8	Dispense as written (DAW)/product selection code	NS	X(1)	
414-DE	Date prescription written	NS	9(8)	
415-DF	Number of refills authorized	NS	9(2)	
419-DJ	Prescription origin code	NS	9(1)	
42Ø-DK	Submission clarification code	NS	9(2)	
46Ø -ET	Quantity prescribed	NS	9(7)V99	
3Ø8-C8	Other coverage code	NS	9(2)	
429-DT	Unit dose indicator	NS	9(1)	
453-EJ	Originally prescribed product/service ID qualifier	NS	X(2)	
445-EA	Originally prescribed product/service code	NS	X(19)	
446-EB	Originally prescribed quantity	NS	9(7)v99	
33Ø -CW	Alternate ID	NS	X(20)	
454-EK	Scheduled prescription ID number	NS	X(12)	
6ØØ-28	Unit of measure	NS	X(2)	
418-DI	Level of service	NS	9(2)	
461-EU	Prior authorization type code	NS	9(1)	
462-EV	Prior authorization number submitted	NS	9(11)	
463-EW	Intermediary authorization type ID	NS	9(2)	
464-EX	Intermediary authorization ID	NS	X(11)	

Field	Field Name	Status	Field Size	Values
343-HD	Dispensing status	S	X(1)	This field is used and required only for partial fill/complete actions. A value of 'P' is required along with the quantity and days' supply intended to be dispensed on the initial fill. A value of 'C' will be required on the completion fill along with the associate pharmacy/service reference number and associate pharmacy/service date.
344-HF	Quantity intended to be dispensed	NS	9(7)V99	
345-HG	Days supply intended to be dispensed	NS	9(3)	

4.5 Pharmacy Provider Segment 02 (Segment not supported for B2 transactions.)

4.6 Prescriber Segment 03 (Segment not supported for B2 transactions.)

4.7 COB/Other Payments Segment 05 (Segment not supported for B2 transactions.)

4.8 Workers' Compensation Segment 06 (Segment not supported for 82 transactions.)

4.9 DUR/PPS Segment 08 (Segment not supported for B2 transactions.)

4.10 Pricing Segment 11 (Segment not supported for B2 transactions.)

4.11 Coupon Segment 09 (Segment not supported for B2 transactions.)

4.12 Compound Segment 10 (Segment not supported for B2 transactions.)

4.13 Prior Authorization Segment 12 (Segment not supported for B2 transactions.)

4.14 Clinical Segment 13 (Segment not supported for B2 transactions.)

5.0 Claim Reversal Response Format – B2

Table Section Key	
M	***Mandatory (for both NCPDP and MA)***
S	***Situational***
O	***Optional***
NS	***Not Supported***
(CC)	***Compound-Code related***
R	***Required (for MA)***
Additional key for status column	******R*** = repeating field***

5.1 Reversal Response (B2) Transmission Level

Segment and all fields are mandatory for all transmissions/transactions.

5.1.1 Response Header Segment

Field	Field Name	Status	Field Size	Values
1Ø2-A2	Version/release number	M	X(2)	51
1Ø3-A3	Transaction code	M	X(2)	B1=Billing B2=Reversal B3=**Rebill**
1∅9-A9	Transaction count	M	X(1)	1=One occurrence 2=Two occurrences 3=Three occurrences 4=Four occurrences For B1-B3 (billing, reversal, and rebill) transactions, transaction count will be a value of 1, 2, 3, or 4. If this transaction is for a compound claim, the transaction count value must be 1.
5Ø1-F1	Header response status	M	X(1)	A=Accepted R=Rejected This is the status of the entire transmission and does not relate to a specific transaction.
202-B2	Service provider ID qualifier	M	X(2)	01 – National provider identifier
201-B1	Service provider ID	M	X(15)	NPI number must be 10 characters. Contact ACS if store location has moved.
4Ø1-D1	Date of service	M	9(8)	CCYYMMDD

5.2 Transaction Level

5.2.1 Response Status Segment 21

Segment is mandatory for all transactions.

Field	Field Name	Status	Field Size	Values
112-AN	Transaction response status	M	X(1)	A=Approved R=Rejected
5Ø3-F3	Authorization number	S	X(20)	ACS sends back when applicable.
51Ø-FA	Reject count	S	9(2)	This field is mandatory when a reject response is returned. This is the count of denied exception codes only.
511-FB	Reject code	S***R***	X(3)	This field is mandatory when a reject response is returned.
546-4F	Reject field occurrence indicator	O	9(2)	This is the number of rejected fields.
526-FQ	Additional message information	O	X(200)	
547-5F	Approved message code count	O	9(1)	Not populated. (Not used for B2.)
548-6F	Approved message code	O***R***	X(3)	Not populated. (Not used for B2.)
549-7F	Help desk phone number qualifier	O	X(2)	Not populated.
55∅-8F	Help desk phone number	O	X(18)	Not populated.

5.2.2 Response Claim Segment 22

Segment is mandatory for all transactions.

Field	Field Name	Status	Field Size	Values
455-EM	Prescription/service reference number qualifier	M	X(1)	1=Rx billing
4Ø2-D2	Prescription/service reference number	M	X(7)	
551-9F	Preferred product count	O	9(1)	Not populated N/A to MA.
552-AP	Preferred product ID qualifier	O***R***	X(2)	Not populated N/A to MA.
553-AR	Preferred product ID	O***R***	X(19)	Not populated N/A to MA.
554-AS	Preferred product incentive	O***R***	9(6)V99	Not populated N/A to MA.
555-AT	Preferred product copay incentive	O***R***	9(6)V99	Not populated N/A to MA.
556-AU	Preferred product description	O***R***	X(40)	Not populated N/A to MA.

6.0 Compound Claims

Pharmacy compound claims must be submitted through POPS for payment. All compounds will be submitted online and contain more than one ingredient. Each ingredient of the compound will be submitted.

All compound claims must be submitted online.

Notes:

- Each compound claim is limited to a maximum of 15 ingredient lines. Providers can submit only a single compound transaction within a single transmission.
- Noncovered ingredients will cause a claim to deny. Each ingredient is subjected to the edits and audits within claim adjudication. If a claim is denied because of a noncovered ingredient, the Provider may agree to accept payment for the approved ingredients making up the compound. To do this, place an '8' in the 'Submission Clarification Code' (Field 420DK). This allows the system to process the compound for the approved ingredients and indicates that, although all the ingredients are not covered, you will accept payment for the approved ingredients only. Compound reversals are processed like other 5.1 transactions.

The compound segment may be submitted only on billing and rebilling requests. It is not sent on claim reversals. This segment contains data describing the compound ingredients. If the segment is submitted, the segment Identification, dosage form description code, dispensing unit form indicator, route of administration, and ingredient component count are required fields according to the standard. Also required are the product ID qualifier, product ID, and ingredient quantity. These three fields may repeat one time for each ingredient in the compound. Compounds may not be submitted as partial fills.

6.1 Compound Segment 1Ø

If Compound Claim = 2-Compound, all fields in this segment (except for Compound Ingredient Basis of Cost Determination) are mandatory.

Field	Field Name	Status	Field Size	Values
45Ø-EF	Compound dosage form description code	M	X(2)	Blank=Not specified Ø1=Capsule Ø2=Ointment Ø3=Cream Ø4=Suppository Ø5=Powder Ø6=Emulsion Ø7=Liquid 1Ø=Tablet 11=Solution 12=Suspension 13=Lotion 14=Shampoo 15=Elixir 16=Syrup 17=Lozenge 18=Enema
451-EG	Compound dispensing unit form indicator	M	9(1)	1=Each 2=Grams 3=Milliliters
452-EH	Compound route of administration	M	9(2)	ØØ=Not specified Ø1=Buccal Ø2=Dental Ø3=Inhalation Ø4=Injection Ø5=Intraperitoneal Ø6=Irrigation Ø7=Mouth/throat Ø8=Mucous membrane Ø9=Nasal 1Ø=Ophthalmic 11=Oral 12=Other/miscellaneous 13=Otic 14=Perfusion 15=Rectal 16=Sublingual 17=Topical Size 18=Transdermal 19=Translingual 2Ø=Urethral 21=Vaginal 22=Enteral
447-EC	Compound ingredient component count	M	9(2)	
488-RE	Compound product ID qualifier	M***R***	X(2)	Ø1=Universal product code (UPC) Ø2=Health-related item (HRI) Ø3=National Drug Code (NDC) (default)

Field	Field Name	Status	Field Size	Values
489-TE	Compound product ID	M***R***	X(19)	
448-ED	Compound ingredient quantity	M***R***	9(7)v999	Metric decimal equivalent
449-EE	Compound ingredient drug cost	R***R***	s9(6)v99	
49∅-UE	Compound ingredient basis of cost determination	O***R***	X(2)	Blank=Not specified Ø1= Average wholesale price (AWP) Ø2=Local wholesaler Ø3=Direct Ø4= Estimated acquisition cost (EAC) Ø5=Acquisition Ø6= Maximum allowable cost (MAC) Ø7=Usual and customary (default) Ø9=Other

7.0 Partial Fill

A partial fill occurs when a pharmacy does not have the full quantity of a drug specified by a prescription to dispense to a patient. The pharmacy dispenses the available quantity. A claim may be submitted for this type of fill, known as a partial fill, whether or not the patient returns to obtain the remainder of the drug quantity. (Sometimes the patient does not return for the remainder.) If the patient does return and receives the remainder of the drug quantity, a claim submitted for this transaction is known as a completion fill.

A pharmacy can submit the following types of claims:

- Partial – Whenever there is a partial fill on a covered drug;
- Completion with a previous partial claim – Whenever a partial fill for which a previous claim was submitted has a completion fill; and
- Completion without a previous partial.

The table below lists the fields that are required for partial-fill transactions, completion-fill transactions, or both.

Field	Field Name	Used with Partial, Completion or
456-EN	Associated prescription/service reference number	Completion
457-EP	Associated prescription/service date	Completion
343-HD	Dispensing status	Both
344-HF	Quantity intended to be dispensed	Both
345-HG	Days' supply intended to be dispensed	Both

7.1 Scenarios

- **Billing claim (B1 Transaction)** – A pharmacy submits a claim for a partial transaction. This is indicated by a 'P' in the 'Dispensing Status' field (Field 343-HD). The claim is priced on its own merit. The entire copayment and dispensing fee is calculated on the partial transaction.
- **Billing claim (B1 Transaction) –** A pharmacy submits claim for a completion transaction and there is a preceding partial transaction for which this is the completion. This is indicated by a 'C' in the 'Dispensing Status' field (Field 343-HD). The claim is priced on its own merit. The entire copayment and dispensing fee is calculated on the partial transaction (see previous bullet). If Other Amount (48Ø-H9) is submitted and is more than the Medicaid liability, the additional Other Amount from the partial transaction is subtracted from the reimbursement amount on the Completion transaction. For example, the MassHealth liability on a partial transaction is $10.00. The Other Amount submitted is $15.00. The system will pay $0.00 on the partial transaction and subtract the remaining Other Amount ($5.00) from the liability on the completion transaction.

If there is an additional Other Amount submitted on the completion claim, the system will subtract this amount from the liability in addition to the $5.00.

- **Billing claim (B1 Transaction) –** A pharmacy submits a claim for a completion transaction. This is indicated by a 'C' in the 'Dispensing Status' filed (Field 343-HD). A matching partial transaction does not exist. The entire dispensing fee is paid. The copayment is not subtracted.
- **Reversal (B2 Transaction) –** A pharmacy submits a reversal for an existing completion transaction. This is indicated by a 'C' in the 'Dispensing Status' field (Field 343-HD).
- **Reversal (B2 Transaction) –** A pharmacy submits reversal for a partial transaction. This is indicated by a 'P' in the 'Dispensing Status' field (Field 343-HD).

Note: If an associated completion transaction exists, it must be reversed first, before the pharmacy can reverse the partial transaction.

7.2 Notes and Requirements

- The values for 'Dispensing Status' are 'P' (partial fill) or 'C' (completion fill). When the remaining quantity is dispensed for a completion, the transaction should:
  - indicate the dispensing status code is for the completion of an existing partial fill;
  - include the associated prescription/service reference number; and
  - include the associated prescription/service date.
- A partial transaction can exist without a companion completion transaction and vice versa (see Scenarios). For example, a partial transaction is submitted due to an inventory shortage. The patient never returns to pick up the quantity that would complete the transaction.
- The entire dispensing fee is paid on the partial transaction.
- The entire dispensing fee is paid on a completion transaction when a matching partial transaction does not exist.

- Copayments are calculated on the partial transaction. If there is a completion transaction without a matching partial transaction, no copayment is subtracted from the completion transaction.
- A completion transaction is not subject to Drug List, DUR, or duration limitations if a matching partial transaction exists.
- A completion transaction will be subject to duplicate check, timely filing, and plan limitations if a matching partial transaction exists.
- The Quantity Intended to Be Dispensed (Field 344-HF) must be greater than Quantity Dispensed (Field 442-E7). Otherwise, the claim will receive reject code E7.
- The Days' Supply Intended to Be Dispensed (Field 345-HG) must be greater than Days' Supply (Field 405-D5). Otherwise, the claim will receive reject code 19.
- The following fields must match when a completion transaction has a corresponding partial transaction:
  - Service provider ID (Field 201-B1),
  - Cardholder ID (Field 3Ø2-C2),
  - Prescription/service reference number (Field 402-D2), fill number (403-D3),
  - Compound code (Field 406-D6),
  - Date prescription written (Field 414-DE),
  - Number of refills authorized (Field 415-DF),
  - Prescription origin code (Field 419-DJ),
  - Quantity intended to be dispensed (Field 344–HF),
  - Days' supply intended to be dispensed (Field 345-HG); and
  - Prescriber ID (Field 411-DB).

  The product/service ID (Field 407-D7) may be a different NDC but must be the same GSN. Associated prescription/service date (Field 457-EP) on the completion transaction must match the date of service (Field 401-D1) on the partial transaction. Failure to conform to any of these requirements will result in reject code P1.
- Dispensing fee submitted (Field 412-DC) is not mandatory on a completion transaction.
- Dispensing status is a required field on reversals.
- The associated prescription/service date field is required on a completion transaction. This field is not required on a partial transaction and may be blank or zero filled.
- When a partial or completion transaction is entered into the system, it will be calculated based on the rate that is effective on the date filled.
- Completion transactions are allowed for compounds only if there is not a matching partial transaction. The pharmacy must submit a reversal if a completion transaction for a compound is submitted that has a matching partial transaction.

- Rx rebills are not allowed for partial or completion transactions.
- Multiple partial transactions for a single dispensing event are not accepted.

8.0 Temporary ID Cards / Newborn IDs

If a claim rejects for eligibility reasons when using a temporary ID card, complete a temporary ID card (request for exception processing consideration) form and fax it to 1-866-556-9313. This form is included in Appendix B or can be obtained by calling the ACS Pharmacy Technical Help Desk at 1-866-246-8503. This form can be photocopied. Within one hour of faxing, the member's pertinent information will be entered into POPS. Please resubmit the claim at that time. For newborns, please follow the same procedures above.

9.0 TPL Billing (Split-billing)

All pharmacy claims submitted to POPS are adjudicated for other insurance coverage, also known as third-party liability (TPL). If primary insurance is listed in the MassHealth member eligibility file, the billing pharmacy must indicate that the insurance was billed prior to submitting the claim to MassHealth. Therefore, all billing pharmacies must have online split-billing capability. After billing the primary payer, enter the appropriate information for the required split-billing fields on the claim submission (see below).

Claims submitted for services for which a member has other pharmacy coverage insurance will be denied unless the claim has been previously submitted to other payers. If the claim is denied, the billing pharmacy receives NCPDP reject code 41 with an additional explanation of benefits (EOB) reason code and additional message text.

Applicable other coverage codes are:

0 = other coverage not specified (default);

1 = no other coverage exists;

2 = other coverage exists - payment collected.*

3 = other coverage exists - this claim not covered;

4 = other coverage exists - payment not collected,*

5 = N/A;

6 = N/A;

7 = other coverage exists-not in effect at time of service; and

8 = claim is a billing for a copay.*

*** Note:** Special expanded guidance is needed for Medicare Part D.

Split-billing requirements (The following fields must be completed for the split-billed claim, coverage codes 2, 3, 4, 7 and 8, to process.):

1. Enter the appropriate code for other insurance from the above list in Field 308 (Other Coverage code).
2. Enter the other payer date (EOB from the primary) in Field 443 (if denial of payment, the primary payer denial date – see note below).
3. Enter the carrier code in Field 340.
4. Enter the other payer amount in Field 431.
5. Enter the 'U' and 'C' price in Field 426 (Usual and Customary Charge).
6. Enter the other payer ID qualifier in Field 339.
7. Enter the other payer coverage type in Field 338.

The MassHealth allowed charge is determined, then the amount paid by the TPL is subtracted to determine reimbursement to the billing pharmacy.

If additional assistance is required, please contact the ACS Pharmacy Technical Help Desk at 1-866-246-8503.

Note: The name of NCPDP Field 443 is 'Other Payer Date'. This term can refer to the date on which other insurance was either paid or denied. If the outcome was a denial, this field may also be referred to in this context as the primary payer denial date.

10.0 90-Day-Waiver Procedures

POPS claims received more than 90 days from the date of service, but less than 12 months, will receive NCPDP reject code 81 (claim exceeds filing limit). The billing pharmacy can obtain a 90-day waiver form from the ACS Pharmacy Technical Help Desk at 1-866-246-8503. This form is included in Appendix A and can be photocopied. The completed form and supporting information can also be faxed to ACS at 1-866-566-9315.

If approved, the billing pharmacy will receive notification that the claim can be submitted to POPS.

(TPL or split bill claims submitted within 90 days of the primary carrier's EOB date do not require a 90-day waiver.)

Providers may apply for a 90-day waiver only in the following certain circumstances:

- reprocessing of a claim (originally paid or denied),
- retroactive member enrollment, and
- retroactive provider enrollment.

11.0 Claims Over $99,999.99

Claims greater than $99,999.99 can be billed online, but these claims will require MassHealth approval. Providers must contact the ACS Pharmacy Technical Help Desk at 1-866-246-8503 to initiate the request.

12.0 Special Topics and References

Some aspects of the billing process are of a narrower perspective than is the target of this billing guide. As such, the more commonly mentioned ones are identified below and an authoritative source of information identified.

Topic	Reference
Return to Stock	MassHealth pharmacy regulations at 130 CMR 406.446
MassHealth 340B Program	MassHealth pharmacy regulations at 130 CMR 406.404

View the MassHealth pharmacy regulations.

13.0 Version Table

Version	Date	Section	Description
1.0	2001	Original document created	Internal document development
2.0	10/03	First major revision of publication	Implemented NCPDP version 5.1 format. Internal document development.
3.0	11/06	Section 3.7 payment segment updated. Deleted text in Sections 7 (Payer Sheet E1) and 8 (Response E1).	First production version issued.
4.0	08/07	Sections 2.1, 2.4, 2.7, 2.10, 3.1-3.2, 4.1 and 5.1.1 have been updated with new NPI information.	Production version issued.

14.0 Where to Get Help

For Assistance with Billing and Claims:

ACS Pharmacy Technical Help Desk	1-866-246-8503 (available 24/7)
ID Card Request Forms:	Fax: 1-866-556-9313
ACS Provider Relations	1-617-423-9830
ACS Provider Relations	MassHealth.Providerrelations@acs-inc.com

Member Eligibility:

Member Services (MAXIMUS)	1-800-841-2900
Automated Voice Response (AVR)	1-800-554-0042

Prior Authorization:

University of Massachusetts Medical School
Phone: 1-800-745-7318
Fax: 1-877-208-7428

Drug Utilization Review Program
Commonwealth Medicine
University of Massachusetts Medical School
100 Century Drive
Worcester, MA 01606

Prior authorization requests for nonpharmacy services including nutritional, enteral, diapers, med/hospital equipment, private duty RN, and PCA should be made to:

MassHealth Prior Authorization Unit
600 Washington Street
Boston, MA 02111

Phone: 1-617-451-7000
Fax: 1-800-862-8341

Provider Enrollment and Credentialing:

1-800-322-2909
Providersupport@mahealth.net

15.0 Appendices

- **Appendix A – Pharmacy 90-Day Waiver Form**
- **Appendix B - Temporary ID Card Form**

Appendix A – Pharmacy 90-day Waiver Form

MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

Pharmacy 90-Day Waiver Form

Use this form to request a 90-day waiver for one of the reasons indicated in the Explanation box below. All fields must be completed to process the request.

Pharmacy information (Required to receive approval notification)

Date	Pharmacy name	Provider number	Fax number	Location code

MassHealth member information

Last name	First name	Date of birth (mmddyyyy)	Gender f m	SSN
Address		City	State	ZIP

Claim information

	Manufacturer	Item	Pkg	Drug name		Quantity	Days' supply
1							
	Prescriber's DEA	Date written	Date filled	Prescription no.	Usual charge	Other pd. amount	Prior auth. no.
2							
3							
4							

Explanation: Please indicate the reason for the 90-day waiver below.

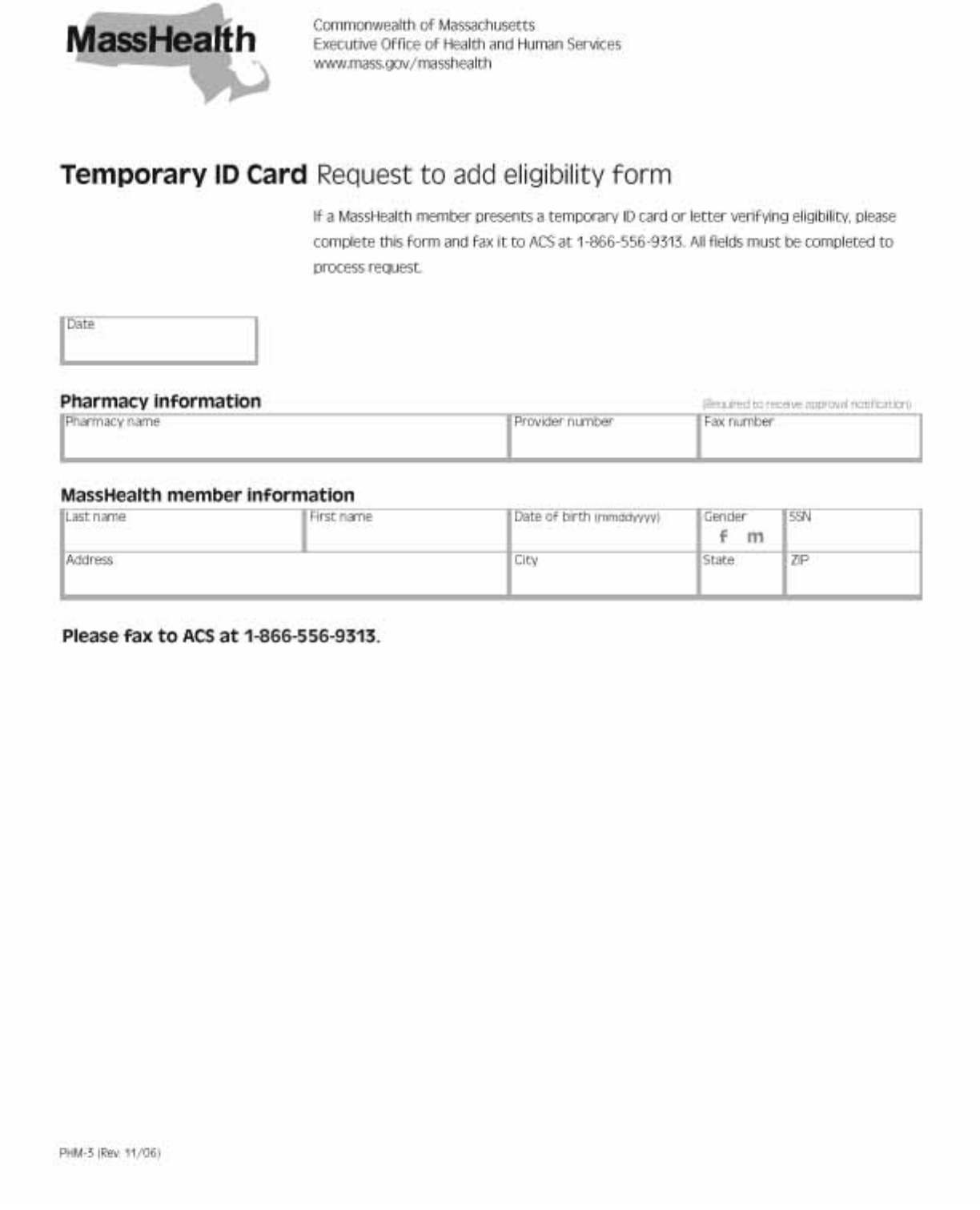
- ☐ Rebilling a previously denied timely filed claim (attach remittance advice)
- ☐ Retroactive member enrollment (attach proof)
- ☐ Retroactive provider enrollment (attach proof)

Please fax the completed form to ACS State Healthcare at 1-866-556-9315:

Note: Submit claims that are older than 12 months (18 months for third party liability claims) directly to: MassHealth , Claims Review Board, Final Deadline Appeals, 600 Washington Street, Boston, MA 02111 (Tel: 617-210-5538).

PHM-2 (Rev. 11/06)

Appendix B – Temporary ID Card Form



MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

Temporary ID Card Request to add eligibility form

If a MassHealth member presents a temporary ID card or letter verifying eligibility, please complete this form and fax it to ACS at 1-866-556-9313. All fields must be completed to process request.

Date

Pharmacy information

(Required to receive approval notification)

Pharmacy name	Provider number	Fax number

MassHealth member information

Last name	First name	Date of birth (mmddyyyy)	Gender f m	SSN
Address		**City**	**State**	**ZIP**

Please fax to ACS at 1-866-556-9313.

PHM-3 (Rev. 11/06)